

Interjurisdictional Tuberculosis Notification

Referring

Jurisdiction city county state Date sent / /
Contact person Phone () FAX ()

☐ Verified case → State where reported: RVCT# (attach RVCT) ☐ Not reported
☐ Suspect case ☐ Close contact ☐ Reactor LTBI ☐ Convertor ☐ Source case investigation

Patient name Sex ☐ Male ☐ Female
 Last First Middle

Date of birth / / Interpreter needed? ☐ No ☐ Yes, specify language

New address Hispanic ☐ No ☐ Yes
 Number/Street/Apt. Race ☐ White ☐ Black ☐ Asian
 City/State/ZipCode ☐ Am.Indian/Nat.Alaskan.
☐ Other:

New telephone () Date of expected arrival / /

New health provider: ☐ Unknown ☐ Known (name, address, phone)

Insurance source: ☐ None ☐ Medicaid ☐ Private ☐ Medicare ☐ Other

Emergency contact: Name Phone

Laboratory information for ☐ this referred case/suspect ☐ index case for this contact ☐ not applicable

| Date | Specimen type | Smear | Culture | Susceptibility | Chest X-ray | Other pertinent labs |
|------|---------------|-------|---------|----------------|-------------|----------------------|
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Site(s) of disease: ☐ Pulmonary ☐ Other(s) specify all

Date 1st negative smear / / ☐ Not yet Date 1st negative culture / / ☐ Not yet

TB skin test #1: Date / / Result mm TB skin test #2: Date / / Result mm

Contact/LTBI Information **TB Skin test** ☐ Not Done

TST #1 Date / / Result mm TST#2 Date / / Result mm

CXR ☐ Not Done Date / / ☐ Normal ☐ Other:

Last known exposure to index case / / Place/intensity of exposure:

Medications ☐ this referred case/suspect ☐ this referred contact/LTBI

| Drug | Dose | Start date | Stop date |
|------|------|------------|-----------|
| | | | |
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Planned completion date / /

DOT ☐ No ☐ Yes: start date / /

☐ Daily ☐ 1x W ☐ 2x W ☐ 3x W

Last DOT Date / /

Adherence problems/significant drug side effects:

Comments

Case Follow-Up In 30 days report to referring jurisdiction if located or not located and report final outcome.

Other Follow-Up ☐ Follow-up requested (form attached) ☐ No follow-up requested